IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
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June 18, 2008

Thair Pond
Tomorrow's Hope - Sapphire
1655 Fairview Avenue Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Sapphire, Provider #13G038

Dear ~~Mr. Pond~~ Thair:

This is to advise you of the findings of the Licensure survey of Tomorrow's Hope - Sapphire, which was conducted on June 12, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 1, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by July 1, 2008. If a request for informal dispute resolution is received after July 1, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

TOMORROW'S HOPE, INC.
1655 FAIRVIEW AVENUE. SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

Debbie Poole Program Director
Tomorrow's Hope
Boise Idaho 83702

Re: Tomorrow's Hope Sapphire survey plan of corrections

Dear Sherri Case,

Here is the plan of correction for Tomorrow's Hope Sapphire please let me know if I need to add or change anything.

Thanks Debbie Poole

PRINTED: 06/18/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G038	A. BUILDING _____ B. WING _____	06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - SAPPHIRE	2154 SAPPHIRE PLACE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Sherri Case, LSW, QMRP Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactive Disorder MAR - Medication Administration Record	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 1 of 3 individuals (Individuals #1) whose medication administration records were reviewed. This resulted in insufficient medical information being maintained for an individual. Findings include: Individual #1's 11/14/07 IPP stated he was diagnosed with moderate mental retardation, ADHD, mood disorder and intermittent explosive disorder. His medication administration records from 8/07 to 5/08 were reviewed. The following dates were noted to have staff's initials circled without an explantation as to why they were circled:	W 111	THe facility has trained on proper medical records documentation on medication sheets (all staff tranined) Staff will check at shift cross over to ensure adequate documentation Nurse and PQ responsible by 6/27/08 -Nurse will review all medicaiton sheets weekly and monthly to ensure proper documentation Nurse responsible by 6/27/08 -QMRP to review medication sheets quarterly to ensure adequate documentation and to be monitorr at the monthy qa QMRP responsible by 6/27/08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

I Debbie Poole PD 6/27/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	Continued From page 1 - 9/4/07 Clonidine (antihypertensive) .1 mg at 8:00 p.m. . - 9/4/07 Depakote (anticonvulsant) 500 mg at 8:00 p.m. - 9/4/07 Seroquel (antipsychotic) 300 mg at 8:00 p.m. - 10/1/07 Seroquel 200 mg at 11:00 a.m. - 10/10/07 Clonidine .1 mg at 8:00 p.m. - 12/11/07 Seroquel 200 mg at 10:00 a.m. - 2/1/07 Straterra 25 mg at 8:00 a.m. - 5/5/07 Straterra 25 mg at 8:00 a.m. - 5/5/07 Clonidine .1 mg at 8:00 a.m. - 5/5/07 Depakote 250 mg at 8:00 a.m. - 5/5/07 Seroquel 200 mg at 8:00 a.m. - 5/9/07 Seroquel 200 mg at 10:00 a.m. - 5/9/07 Seroquel 200 mg at 8:00 p.m. - 5/12/07 Seroquel 200 mg at 10:00 a.m. - 5/18/07 Seroquel 200 mg at 10:00 a.m. When asked during interview, on 6/12/08 from 10:00 - 11:30 a.m., if the individual had received the medications listed above the QMRP stated yes. She stated an explanation for the circled initals should have been documented on the back of the MAR and the MAR was not accurate. The facility failed to ensure an accurate MAR was maintained for Individual #1.	W 111		

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MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - 6) residing in the facility. The findings include: An environmental review was conducted at the facility on 6/11/08 from 1:00 - 1:35 p.m. and the following concerns were noted: - An 8 inch by 8 inch Pyrex baking dish had burned on grease on it. - Individual #2's dresser was missing finish in numerous areas. - The baseboard in Individual #5's bedroom was missing paint in several areas. - The screen in Individuals #3 and #4's bedroom had a gap approximately 1/8 inch between the window frame and the screen. - The bedroom window sill for Individuals #3 and #4 had dust and leaves on it. - The baseboard in the library was missing paint in several areas.	MM380	MM380 Identified deficiencies ill be cleaned, repaired, or replaced as need to meet requirments PQ responsiple by 6/27/08	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Debbie Poole PD — (X6) DATE: 6/27/08

STATE FORM 6899 DMBC11 If continuation sheet 1 of 2

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MM428	Continued From page 1	MM428		
MM428	16.03.11.120.10(c) Tempeature of hot water The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 6 of 6 individuals, (Individuals #1 - #6) residing at the facility. Findings include: An environmental survey was conducted at the facility on 6/11/08 from 1:00 - 1:30 p.m., and showed the following hot water temperatures: Kitchen sink - initially at 123.1 degree but decreased to 89 degrees. Hallway bathroom - initially at 88 degrees but decreased to 76 degrees.	MM428	MM428 The facility has adjusted water tempt s to range betwen 105 and 120. PQ and Maintenance responsible 6/27/08 Weekly water tempts to be taken to ensure adequate water tempts PQ responsible 6/27/08 Water tempts will be reviewed with household maintenance at monthly QA PQ Q responsible	
MM570	16.03.11.210.05(b) Meidcations and Treatments A record of all medications and treatments prescribed and administered; and This Rule is not met as evidenced by: Refer to W111.	MM570	MM570 refer to tag W111	